

## § 162.100

162.1202 Standards for eligibility for a health plan transaction.

### Subpart M—Referral Certification and Authorization

162.1301 Referral certification and authorization transaction.

162.1302 Standard for referral certification and authorization transaction.

### Subpart N—Health Care Claim Status

162.1401 Health care claim status transaction.

162.1402 Standards for health care claim status transaction.

### Subpart O—Enrollment and Disenrollment in a Health Plan

162.1501 Enrollment and disenrollment in a health plan transaction.

162.1502 Standards for enrollment and disenrollment in a health plan transaction.

### Subpart P—Health Care Payment and Remittance Advice

162.1601 Health care payment and remittance advice transaction.

162.1602 Standards for health care payment and remittance advice transaction.

### Subpart Q—Health Plan Premium Payments

162.1701 Health plan premium payments transaction.

162.1702 Standards for health plan premium payments transaction.

### Subpart R—Coordination of Benefits

162.1801 Coordination of benefits transaction.

162.1802 Standards for coordination of benefits information transaction.

AUTHORITY: Secs. 1171 through 1179 of the Social Security Act (42 U.S.C. 1320d-1320d-8), as added by sec. 262 of Pub. L. 104-191, 110 Stat. 2021-2031, and sec. 264 of Pub. L. 104-191, 110 Stat. 2033-2034 (42 U.S.C. 1320d-2 (note)).

SOURCE: 65 FR 50367, Aug. 17, 2000, unless otherwise noted.

### Subpart A—General Provisions

#### § 162.100 Applicability.

Covered entities (as defined in § 160.103 of this subchapter) must comply with the applicable requirements of this part.

## 45 CFR Subtitle A (10-1-03 Edition)

#### § 162.103 Definitions.

For purposes of this part, the following definitions apply:

*Code set* means any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

*Code set maintaining organization* means an organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted in this part.

*Data condition* means the rule that describes the circumstances under which a covered entity must use a particular data element or segment.

*Data content* means all the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content.

*Data element* means the smallest named unit of information in a transaction.

*Data set* means a semantically meaningful unit of information exchanged between two parties to a transaction.

*Descriptor* means the text defining a code.

*Designated standard maintenance organization (DSMO)* means an organization designated by the Secretary under § 162.910(a).

*Direct data entry* means the direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer.

*Format* refers to those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

*HCPCS* stands for the Health [Care Financing Administration] Common Procedure Coding System.

*Maintain* or *maintenance* refers to activities necessary to support the use of a standard adopted by the Secretary, including technical corrections to an implementation specification, and enhancements or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or